

(1) General Overview

Beginning April 1, 2003, the Department will pay for inpatient hospital services in general acute care hospitals under a DRG-based methodology. The methodology is based on the Medicare Prospective Payment System. Generally, all rates (operating and capital), relative weights, and payment logic have been adopted from Medicare. The relative weights have been adjusted for Medicaid average length of stay and budget neutrality.

Certain facilities and services are excluded from the DRG methodology and will continue under a prospective per diem methodology. The following will be excluded from the DRG methodology:

- a) Critical access hospitals
- b) Freestanding rehabilitation hospitals
- c) Long-term care hospitals
- d) Psychiatric services in acute care hospitals
- e) Psychiatric hospitals; and
- f) Transplants, other than kidney, pancreas, and cornea.

(2) Acute Care Hospital Services

A. DRG-Based Methodology

1. Participating acute care hospitals will be paid on a fully prospective per discharge basis for general acute care services and rehabilitation services. The total per discharge payment shall be the sum of an operating payment, a capital-related payment, and if applicable, a cost outlier payment.

a. Operating Payment

The operating payment will be based on a patient's DRG classification, as assigned by the Medicare DRG classification system. A operating payment will be calculated for each discharge by multiplying a hospital's operating base rate by the Medicaid-specific DRG relative weight which has been adjusted for budget neutrality.

The operating base rate for each hospital will be the Medicare national standardized amount as adjusted by Medicare using the Medicare wage index. The labor portion of the operating base rate will be multiplied by the hospital's wage index and added to the non-labor portion of the hospital's operating base rate. This amount will be adjusted by the Medicare indirect medical education operating adjustment factor. (Adjusted operating base rate X (1 + IME)) The Medicare DSH operating adjustment factor will not be included in the calculation of the operating base rate.

The adjusted Medicare national standardized amount will be calculated based on the Medicare rate data published in the *Federal Register* effective on October 1 of the year immediately preceding the universal rate year. There will be no consideration given to adjustments made by Medicare after October 1 of the year preceding the universal rate year.

b. Capital-Related Payment

The capital-related payment will be calculated for each discharge by multiplying the capital-related base rate by the Medicaid-specific DRG relative weight which has been adjusted for budget neutrality. The capital-related base rate for each hospital will be the Medicare standard federal capital rate, as adjusted by Medicare for each hospital using the Medicare large urban-area adjustment factor, if applicable, the Medicare geographic adjustment factor, and the Medicare indirect medical education capital adjustment factor. The Medicare DSH capital adjustment factor will not be included in the calculation. The adjusted Medicare standard federal capital rate will be calculated based on the Medicare rate data published in the *Federal Register* effective on October 1 of the year immediately preceding the universal rate year.

c. Cost Outlier Payment

A cost outlier payment will be made for a discharge if the estimated cost of the discharge exceeds the DRG's outlier threshold of \$29,000. The estimated cost of the discharge is determined by multiplying the charges for the discharge by the facility-specific Medicare cost-to-charge ratio obtained from the Medicare fiscal intermediary. Payment for a cost outlier will be eighty (80) percent of the amount that estimated costs exceed the discharge's outlier threshold.

2. Relative Weights

Kentucky Medicaid-specific DRG relative weights are based on Medicaid base year claims data. Claims are assigned to Medicare DRG classifications using the Medicare grouper. Claims data for discharges that are to be reimbursed on a per diem basis are removed from the calculation.

A statewide Medicaid arithmetic mean length-of-stay (ALOS) per discharge is determined for each DRG classification. Relative weights are calculated for each DRG by multiplying the Medicare relative weight by the ratio of the Medicaid ALOS to the Medicare ALOS multiplied by the budget neutrality (BN) factor as follows:

Medicaid relative weight =
Medicare relative weight X Medicaid ALOS/ Medicare ALOS X BN
factor

Medicare DRG relative weights and arithmetic mean length-of-stay will be those published in the *Federal Register* effective on October 1 of the year immediately preceding the universal rate year.

3. DRG Classifications

Discharges will be assigned based on the Medicare grouper in effect October 1 prior to the beginning of the universal rate year except that a unique set of DRGs and relative weights have been established for Level III neonatal cases. Claims classified into DRGs 385 through 390 from Level III neonatal centers will be identified and reassigned to DRGs 685 through 690 respectively. Relative weights for these DRGs will be determined as described in 2 above using the Medicare ALOS for DRGs 385 through 390. Only Level III neonatal centers will receive payments for DRGs 685 through 690.

4. Indirect Medical Education Adjustment Factor

An indirect medical education adjustment factor will be the same indirect medical education factor used by Medicare for Medicare rates effective on October 1 of the year immediately preceding the universal rate year. The adjustment factor will include a operating and capital component. The ratio of interns and residents to available beds in the Medicare formula will be obtained from the Medicare fiscal intermediary.

5. Direct Graduate Medical Education

The Department will reimburse separately for the direct costs associated with a Medicare approved graduate medical education (GME) program. The Department will make annual payments calculated as follows:

The Department will compare the hospital-specific and national average Medicare per intern and resident amounts as of October 1 immediately preceding the rate year. The hospital's number of interns and residents will be multiplied by the higher of the two amounts. The result is an estimate of total direct graduate medical education costs. The estimated total direct medical education costs will be divided by the number of total inpatient days as reported on Worksheet D, Part 1 of a hospital's most recently audited cost report to determine the average GME cost per day. The GME cost per day will be multiplied by the number of covered days, (including psychiatric days) reported in the base year claims data to determine total GME costs. Total GME costs will be multiplied by the budget neutrality factor to determine final payments.

The base year will be the calendar year ending 18 months prior to the beginning of the rebase year that begins July 1.

6. Transfers

If a patient is transferred to or from another hospital, the department will make a transfer payment if the initial admission and the transfer are determined to be medically necessary. The Department will pay the transferring hospital the average daily rate of the appropriate DRG for each covered day the patient

remains in the hospital, plus one (1) day, not to exceed the full DRG payment. The per diem will be calculated by dividing the DRG payment by the Medicaid average length-of-stay for the DRG.

The Department will pay the hospital receiving a transferred patient the full DRG payment, and if applicable, a cost outlier payment.

7. Post-acute Care Transfer

A transfer from an acute care hospital to a qualifying post-acute care facility for specified DRGs for services related to the diagnoses for inpatient services provided within 3 days of date of discharge will be treated as a post-acute transfer. The specified DRGs include DRG 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483. Post acute-care settings include psychiatric, rehabilitation, children's, long-term acute care and cancer hospitals; skilled nursing facilities; and home health agencies. A hospital swing-bed is not considered a post-acute care setting.

Each transferring hospital will be paid a per diem rate for each day of stay. No payment will exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

DRGs 209, 210, and 211 will be paid at fifty (50) percent of the full DRG payment plus the per diem for the first day of the stay and fifty (50) percent of the per diem for the remaining days of the stay, up to the full DRG payment. DRGs 14, 113, 236, 263, 264, 429, and 483 will be paid at twice the per diem rate for the first day and the per diem rate for each following day of the stay prior to the transfer. The per diem amount will be the full DRG divided by the statewide Medicaid average length of stay for that DRG.

8. Pre-admission Services

Outpatient services provided within three (3) calendar days of an inpatient admission for the same or related diagnosis will be included in the inpatient billing and will not be billed separately. This will not include a service furnished by a home health agency, a skilled nursing facility, hospice, or outpatient

maintenance dialysis, unless the service is a diagnostic service related to an inpatient admission.

9. Readmission

An inpatient admission within thirty (30) calendar days of discharge for the same diagnosis will be considered a readmission and will not be reimbursed as a separate admission.

10. Supplemental DRG Payments

The Department will make a supplemental payment for DRGs 385 through 390 to a hospital with a Level II neonatal intensive care unit that meets the following qualifications:

- a. Is licensed for a minimum of 24 neonatal level II beds;
- b. Has a minimum of 1,500 Medicaid neonatal level II patient days per year;
- c. Has a gestational age lower limit of twenty-seven (27) weeks; and
- d. Has a full-time perinatologist on staff.

The payment will be an additional payment of \$3,775 add-on per discharge for each of the above DRGs.

B. Per Diem Methodology

1. Inpatient Psychiatric Services in Acute Care Hospitals

The Department will pay for inpatient psychiatric services provided in licensed psychiatric bed on a per diem basis beginning April 1, 2003. Payment will be determined by multiplying a hospital's psychiatric per diem rate by the number of allowed patient days.

The psychiatric per diem rate will be the sum of the facility-specific psychiatric operating per diem rate and the psychiatric capital per diem rate, adjusted for budget neutrality.

The psychiatric operating cost per day amounts used to determine the psychiatric operating per diem rate will be calculated for each hospital by dividing its Medicaid psychiatric cost basis, excluding capital costs, by the number of Medicaid psychiatric patient days in the base year. The Medicaid psychiatric cost basis and patient days will be based on Medicaid claims for patients with a primary psychiatric diagnosis in the base year. The psychiatric operating per diem rate will be adjusted for:

- a. The price level increase from the mid-point of the base year to the mid-point of the universal rate year using the CMS Input Price Index;
- b. The change in the Medicare published wage index from the base year to the universal rate year applied to the labor portion of the rate; and
- c. The budget neutrality factor.

The psychiatric capital per diem rate will be the facility-specific psychiatric capital cost per day, adjusted by the budget neutrality factor. Depreciation on buildings and fixtures will be limited to sixty-five (65) percent of depreciation reported on the annual cost report.

The base year will be the calendar year ending 18 months prior to the beginning of the rebase year that begins July 1.

The Department will pay for psychiatric services in acute care hospitals without licensed psychiatric services at a per diem rate equal to the median rate for all licensed psychiatric beds as described above.

2. Wage Index and Wage Area

The Department will use the wage index published by CMS in the *Federal Register* on October 1 immediately preceding the universal base rate year. The Department will assign a hospital to either the wage area in which it is physically located as originally classified by CMS for the Medicare program for the base year; or the wage area to which a hospital has been reclassified by the Medicare Geographic Classification Review Board for the base year.

The Department will not consider reclassification of a hospital to a new wage area except during a rebase period.

C. Budget Neutrality Factor

In the year of implementation, the Department will apply a budget neutrality factor to assure that estimated payments under the DRG and per diem methodologies in the universal rate year will not exceed payments in the prior year, adjusted for inflation using the CMS Input Price Index.

The budget neutrality factor is determined based on a modeling approach using base year claims. The base year will be the calendar year ending 18 months prior to the beginning of the rate year that begins on July 1. The budget neutrality factor will be calculated as follows:

1. Total payments under the reimbursement methodology in effect in the prior year are estimated using base year claims.
2. Total payments under the new reimbursement methodology are estimated using the plan year rates and relative weights, before any budget neutrality adjustments, using the same base year claims in Step 1.
3. The sum of payments for all facilities in Step 1 are compared to the sum of payments for all facilities in Step 2.
4. If the sum of payments for all facilities in Step 2 exceeds the sum of payments for all facilities in Step 1, the following rate components are reduced proportionally so that the sum of payments for all facilities in Step 2 and Step 1 are equal:
 - a. DRG relative weights;
 - b. Psychiatric operating per diem rates;
 - c. Psychiatric capital per diem rates; and
 - d. Graduate medical education payments.
5. The percentage reduction that is applied to the above rate components so that the sum of payments for all facilities in Step 2 is equal to the sum of payments for all facilities in Step 1 is the budget neutrality factor.

D. Reimbursement Updating Procedures

The Department will adjust per discharge base rates and psychiatric per diem rates annually beginning July 1, 2004. The department will adjust DRG rates on July 1 using the Medicare DRG base rate in effect October 1 of the preceding year as published in the *Federal Register*.

The Department will adjust psychiatric per diem rates by inflating the psychiatric operating per diem from the mid-point of the previous universal rate year to the mid-point of the current universal rate year using the CMS Input Price Index. The psychiatric capital per diem rate will not be adjusted.

DRG relative weights, and other applicable components (Graduate Medical Education, cost-to-charge ratios, outlier thresholds) of the payment rates will be updated every three (3) years using the most recent audited cost report and Medicare rate data available to the department.

E. Use of a Universal Rate Year

Except for the first year of the DRG system, a universal rate year will be established as July 1 through June 30 of each year to coincide with the state

fiscal year. In the first year of the DRG system, the universal rate year will be the fifteen-(15) month period from April 1, 2003 through June 30, 2004. A hospital will not be required to change its fiscal year to conform to the universal rate year.

F. Provider Appeal Rights

An administrative review will not be available for the following:

- a. A determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rate; or
- b. The establishment of (DRGs);
- c. The methodology for the classification of an inpatient discharge within each DRG; or
- d. Appropriate weighting factors that reflect the relative hospital resources used with respect to discharge within each DRG.
- e. The determination of the requirement or the proportional amount of any budget neutrality adjustment.

An administrative review shall be available for a calculation error in the establishment of a per diem rate.

(3) Reimbursement for Out-of-state Acute Care Hospitals

- A. An acute care out-of-state hospital will be reimbursed for an inpatient acute care service and an inpatient rehabilitation service in an acute care hospital on a fully prospective per discharge basis for the universal rate year beginning on or after April 1, 2003. The total per discharge reimbursement will be the sum of an operating payment, a capital-related payment, and, if applicable, a cost outlier payment.
- B. The operating payment will be based on the patient's Medicare DRG classification. The operating payment will be calculated for each discharge by multiplying a hospital's operating base rate by the Kentucky-specific DRG relative weight. A hospital's operating base rate will be the Medicare national standardized amount, as adjusted by Medicare for each hospital using the Medicare wage index. Amounts for out-of-state providers will not include the Medicare DSH operating adjustment factor or the Medicare indirect medical education operating adjustment factor.
- C. The capital-related payment will be made on a per discharge basis. The capital-related payment will be calculated for each discharge by multiplying a hospital's capital-related base rate by the Kentucky-specific DRG relative weight. A hospital's capital-related base rate will be the Medicare federal

capital rate, as adjusted by Medicare for each hospital using the Medicare large urban-area adjustment factor when applicable and the Medicare geographic adjustment factor as published in the Federal Register. Amounts for out-of-state providers will not include the Medicare DSH capital adjustment factor or the Medicare indirect medical education capital adjustment factor.

- D. A cost outlier payment will be made by using the same method and criteria used to determine the payment for in-state claims.
- E. An acute care out-of-state hospital will be reimbursed for an inpatient psychiatric service on a fully prospective per diem basis for the universal rate year beginning on or after April 1, 2003. Reimbursement for an inpatient psychiatric service will be determined by multiplying a hospital's psychiatric per diem rate by the number of allowed patient days.
- F. A psychiatric per diem rate will be the sum of a psychiatric operating per diem rate and a psychiatric capital per diem rate. The psychiatric operating per diem rate will be the median operating cost per day, excluding graduate medical education, for all acute care in-state hospitals that have licensed psychiatric beds. The psychiatric capital per diem rate will be the median psychiatric capital per diem rate for all acute care in-state hospitals that have licensed psychiatric beds.

(4) Critical Access Hospitals

The Department pays for inpatient services provided by in-state critical access hospitals through an interim per diem rate as established by the Centers for Medicare and Medicaid Services (CMS) for the Medicare Program. The effective date of a rate will be the same as used by the Medicare Program. Critical access hospitals will be required to submit an annual Medicare/Medicaid cost report. Payments will be settled to actual costs based on final audited cost reports. Total payments made to critical access hospital will be subject to the payment limitation in 42 CFR 447.271.

(5) Rehabilitation Hospitals, Long-term Acute Care Hospitals, and Psychiatric Hospitals.

- A. Hospitals covered under this section are excluded from the DRG reimbursement system and will be reimbursed under a per diem methodology. Rehabilitation hospitals, long-term acute care hospitals, and psychiatric hospitals will be paid through a prospective cost-based per diem reimbursement system based on allowable costs and allowable patient days. The per diem includes an operating component, a capital component, and, if applicable a professional component.

Using the most recently submitted cost report available as of May 1 of each year, costs will be trended to the beginning of the rate year and indexed (adjusted for inflation) for the prospective rate year. Rates based on

unaudited data will be revised upon receipt of an audited cost report from the fiscal intermediary or an independent audit firm. Prospective rates include both inpatient routine and inpatient ancillary costs using and are based on the following:

1. Allowable Medicaid inpatient operating costs are determined based on Medicare cost finding principles. Medicaid inpatient operating costs as reported on the cost report are trended to the beginning of the rate year and increased for inflation by the Data Resources Index. Operating costs are divided by allowable Medicaid inpatient days to establish an operating per diem.
2. Allowable Medicaid inpatient capital costs are determined based on Medicare cost finding principles except that inpatient building and fixtures depreciation is limited to sixty-five (65) percent of the amount reported. Capital costs are not trended or indexed for inflation.

Allowable capital costs will be reduced if a minimum occupancy factor is not met by artificially increasing the occupancy factor to the minimum factor, and calculating the capital costs based on the minimum factor. A sixty (60) percent occupancy factor will apply to hospitals with 100 or few beds, and a seventy-five (75) percent occupancy factor will apply to hospitals with 101 or more beds.

3. Allowable Medicaid inpatient professional costs are determined by the Data Resources Index to project current year costs. A professional cost component is computed by dividing Medicaid professional costs by Medicaid allowable days.
4. Provider taxes will be included as allowable costs.
5. Unallowable costs are to be reported on a Supplemental schedule and include:
 - a. Costs associated with political contributions.
 - b. The costs associated with legal fees for unsuccessful lawsuits against the Cabinet. Legal fees relating to successful lawsuits against the Cabinet will only be included in the period in which the suit is settled after a final decision by the Courts or by agreement by the parties involved.

- c. The costs for travel and associated expenses outside the Commonwealth for conventions, assemblies, etc. or related activities. Costs (excluding transportation) for educational purposes will be allowable costs.

Cost reports and all supplements are to be submitted annually within five (5) months after the close of the hospital's fiscal year. Extensions will not be granted. The Department will suspend payments until an acceptable cost report is filed.

B. Additional Provisions for Psychiatric Hospitals

Psychiatric hospitals will have an upper limit established at the weighted median of the array of allowable costs for all participating psychiatric hospitals. Hospitals having a Medicaid utilization of thirty-five (35) percent or higher will have an upper limit established at one-hundred and fifteen (115) percent of the weighted median. There will be no limit on depreciation.

(6) New Providers/Change of Ownership

If a hospital undergoes a change of ownership, the new owner will be reimbursed at the rate of the former provider. If at the time of the next prospective rate setting, the hospital does not have twelve (12) full months of actual costs data, the department will base its prospective rate on a partial year. The partial year data will be annualized and indexed appropriately.

Until a fiscal year end cost report is available, newly constructed or participating providers will submit an operating budget and projected number of patient days within 30 days of enrolling as a provider. A tentative rate will be set based on data with a final rate determined after receipt of an audited cost report. The limitations described under this section will apply.

For a newly enrolled provider in a non-rebase year, costs and per diems will be trended and indexed to the base year to establish a base year per diem. The base year per diems will then be adjusted to account for historical inflationary rate increases received by other providers. For example: A provider participating for the first time in SFY 2003 rates would be based on current costs which would be trended back to 1997 to correspond to the base year costs for other providers. After determining the base year costs, costs would be trended and indexed to 1998 to

establish a prospective rate for 1998. From 1998 to the current rate year, the 1998 rate would be adjusted in the same manner as other providers; i.e. in 1999 a 3% rate increase; 2000 a 2.8% rate increase; 2001 rates were frozen; 2002 rates were frozen, etc.

(7) Out-Of State

An out-of-state rehabilitation hospital, psychiatric hospital, or critical access hospital will be reimbursed for an inpatient service on a fully prospective per diem basis for the universal rate year beginning on or after April 1, 2003. The per diem rate will be the median per diem rate for the appropriate classification of hospital. The median will be calculated at the beginning of each universal rate year.

- (8) For the universal rate year April 1, 2003 through June 30, 2004, rehabilitation hospitals, long-term acute care hospitals, and psychiatric hospitals will continue to be paid the per diem in effect for the rate year beginning July 1, 2002.

(9) Disproportionate Share Hospital Provisions

A. Definition. A *disproportionate share hospital* is a hospital that (a) has a Medicaid utilization rate of not less than one percent; and (b) has at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to services under the state Medicaid plan. The term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This provision shall not apply to a hospital that did not offer non-emergency obstetric services as of December 21, 1987.

B. Hospitals are classified as follows:

- a. Type I hospitals are hospitals with 100 beds or less;
- b. Type II hospitals are hospitals with more than 100 beds that are not Type III or Type IV hospitals;
- c. Type III hospitals are state university teaching hospitals; and
- d. Type IV hospitals are state-owned mental hospitals.

C. Annually the Department shall determine a sum of funds to be allocated to each classification of hospitals in accordance with state and federal law as follows:

- a. Non state-owned acute care hospitals are allocated 43.92% of the total federal/state allotment. (Type I and Type II hospitals)
- b. State university teaching hospitals are allocated 37% of the total federal/state allotment. (Type III hospitals)

- c. Mental hospitals (including private and state-owned facilities) are allocated 19.08% of the total federal/state allotment. (Type IV hospitals)
- d. Any funds not distributed in any pool due to the limit in J. may be transferred to another pool and distributed according to the provisions below.
- D. Disproportionate share hospital payments shall be fully prospective amounts determined in advance of the state fiscal year to which they apply, and shall not be subject to settlement or revision based on changes in utilization during the year to which they apply. Payments prospectively determined for each state fiscal year shall be considered payment for that year, and not for the year from which patient and cost data used in the calculation was taken.
- E. The Department will use patient and cost data from the most recently completed state fiscal year. DSH payments shall be made on an annual basis.
- F. Payments will be distributed to Type I and Type II hospitals based upon each hospital's proportion of indigent costs determined as follows:
- Indigent Costs
Total Indigent Costs X Available Fund = DSH Payment
- Indigent costs* include the inpatient and outpatient costs of providing care to indigent patients. Indigent patients include patients without health insurance or other source of third party payment with incomes below 100% of the federal poverty level.
- G. Payments will be distributed to Type III hospitals based upon each facility's percentage of the total pool funds received in SFY 1999. This percentage is applied to current allocated funds.
- H. Payments will be distributed to Type IV hospitals based upon each facility's proportion of uncompensated costs. Uncompensated costs include the costs of care for indigent patients and uninsured patients.
- I. Except for State Fiscal Years 2004 and 2005, payments to Type III and Type IV hospitals shall not exceed the sum of the costs of providing inpatient and outpatient services to Medicaid patients, less the amount paid under the nondisproportionate share provisions and the costs of services to both uninsured and indigent patients, less any payments made. For State Fiscal Years 2004 and 2005, payments shall not exceed the limitation in L.

Indigent patients are defined in state law as individuals without health insurance or other sources of third party payment with incomes below 100% of the federal poverty level.

Uninsured patients are patients who have no health insurance or other sources of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment or who has exhausted his/her benefits. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.

- J. The disproportionate share hospital payment shall be an amount that is reasonably related to costs, volume, or proportion of services provided to patients eligible for medical assistance and to low income patients.
- K. Limit on Amount of Disproportionate Share Payment to a Hospital.
Payments made under these provisions do not exceed the OBRA '93 limits described in 1923 (g) of the Social Security Act. This limit is the sum of the following two measurements that determine uncompensated costs: (a) Medicaid shortfall; and (b) costs of services to uninsured patients less any payments received. *Medicaid shortfall* is the cost of services (inpatient and outpatient) furnished to Medicaid patients, less the amount paid under the nondisproportionate share hospital payment method under this state plan. The *cost of services* to the uninsured includes inpatient and outpatient services. Costs shall be determined by multiplying a hospital's cost to charge ratio by its uncompensated charges. *Uninsured patients* are patients who have no health insurance or other sources of third party payments for services provided during the year. Uninsured patients include those patients who do not possess health insurance that would apply to the service for which the individual sought treatment or who has exhausted his/her benefits. Payments made by any unit of the Commonwealth or local government to a hospital for services provided to indigent patients shall not be considered to be a source of third party payment.
- L. Funds not distributed under the above provisions due to the limit in L. may be redistributed to public hospitals who are located in the state's managed care region based on the following:

Medicaid Days

Total Medicaid Days X Remaining Funds = DSH Payment

Funds available for redistribution will be allocated to state teaching hospitals (Type III) to cover their uncompensated costs and then to public non-state providers (Type I and Type II). *Medicaid days* shall be based on the number of inpatient Medicaid days reported on the most recently completed cost report. Medicaid days shall include days provided under FFS and through a managed care entity.

- M. For state fiscal years beginning July 1, 2003 and July 1, 2004, payments to public hospitals may not exceed 175% of a hospital's uncompensated care costs as described in L.

(10) Public Process for Determining Rates for Inpatient Hospitals

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

TN No. 98-04

Supersedes

TN No. None

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(11) Payments for Inpatient Psychiatric Facility Services for Individuals Under 22 Years of Age

(A) Covered inpatient psychiatric facility services for individuals under 22 years of age provided in psychiatric hospitals are paid in accordance with the provisions described in Attachment 4.19-A

(B) Covered inpatient psychiatric facility services for individuals under 22 years of age provided in licensed psychiatric resident treatment facilities (PRTFs) are paid in accordance with the following:

(1) The PRTFs shall be paid a fixed per diem rate of \$230 which shall be adjusted upward each biennium by 2.22 percent or the usual and customary charge, if less. The payments shall not exceed prevailing charges in the locality for comparable services provided under comparable circumstances. The fixed rate (upper limit) is the state's best estimate of the reasonable and adequate cost of providing the services. This rate is determined in the following manner:

(a) Facilities that provide services that meet the criteria for PRTFs are requested to submit their actual costs for covered services. These costs shall include all care and treatment, staffing, ancillary services (excluding drugs), capital, and room and board costs.

(b) The actual costs submitted by the facilities are compared to the costs estimated to operate a model PRTF. The costs of the model facility and current facilities are analyzed on the basis of their being reasonable and adequate to meet the costs which would be incurred in order to provide quality services in an economic and efficient manner.

(c) From this analysis and a consideration of the comments from the facilities, a uniform per diem rate is established for all participating facilities.

(d) This per diem rate is then adjusted for inflation by 2.22 percent biennium. This inflation rate is based upon the historic rate of inflation as applied to these facilities and their necessary increases in costs of providing the services.

(2) The fixed rate or usual and customary charge, if less, covers total facility costs for PRTF services including the following: all care and treatment costs, staffing, costs for ancillary services (except drugs), capital costs, and room and board costs. The rate is established to be fair and adequate compensation for services provided to Medicaid beneficiaries.

(12) Intensity Operating Allowance Inpatient Supplement.

Beginning July 1, 2003, a state designated pediatric hospital that is state-owned or operated and qualifies as a Type III DSH hospital shall receive an enhanced payment for the current rate year. This payment shall be an amount that is equal to the difference between the payments made by Medicaid and an estimate of Medicare payments for the same services based on Medicare principles of reimbursement as specified in 42 CFR 447.272. The limitation in 42 CFR 447.272 will be applied on a facility-specific basis.

Any payments made under this section are subject to the payment limitations as specified in 42 CFR 447.271, whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services

Payments made under this section shall be prospectively determined quarterly amounts, subject to the same limitations and conditions as above.

In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by the Health Care Financing Administration, the Department shall adjust the payments made to any hospitals as necessary to qualify for FFP.

(12) Intensity Operating Allowance Inpatient Supplement (cont.)

A state designated pediatric teaching hospital that is not state-owned or operated shall receive a quarterly pediatric teaching supplement in an amount:

1. Determined on a per diem or per discharge basis equal to the unreimbursed costs of providing care to Medicaid recipients under the age of 18; plus
2. \$250,000 (\$1 million annually).

Medicaid recipients shall not include recipients receiving services reimbursed through a Medicaid managed care contract.

(13) Payment Not to Exceed Charges

The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges-plus-disproportionate share, in aggregate, for inpatient hospital services provided to Medicaid recipients. The state fiscal year is July 1 through June 30. If an individual hospital's overall payments for the period exceed charges, the state will recoup payments in excess of allowable charges-plus-disproportionate share.

(14) Limit on Amount of Disproportionate Share Payment to a Hospital

A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for Medicaid recipient services and the costs of uninsured patients. (Section 1923(g) of the Social Security Act.)

Payment Shortfall for Medicaid Recipient Services. The payment shortfall for Medicaid recipient services is the amount by which the costs of inpatient and outpatient services provided Medicaid recipients exceed the payments made to the hospital for those services excluding disproportionate share payments.

Unrecovered Cost of Uninsured/Indigent Patients. The unrecovered cost of uninsured/indigent patients is the amount by which the costs of inpatient and outpatient services provided to uninsured/indigent patients exceed any cash payments made by them. An uninsured/indigent patient is an individual who has no health insurance and meets income standards established in state law.

(15) Supplemental Payment for Urban Trauma Center Hospitals

Supplemental payments are provided for Type III hospitals that qualify as urban trauma centers.

A. A hospital qualifies as an urban trauma center if it meets the following:

1. The hospital is designated as a Level I Trauma Center by the American College of Surgeons;
2. The hospital has a Medicaid utilization rate greater than 25%; and
3. At least 50% of its Medicaid population are residents of the county in which the hospital is located.

Medicaid utilization rate is the rate derived by dividing a hospital's total Medicaid days by the total patient days, which includes days reimbursed through a managed care entity and fee-for-service.

B. The supplemental payment amount will be determined as follows:

Step 1: The average payment rate per Medicare case with case mix removed will be calculated by dividing all Medicare payments subject to case mix by the Medicare case mix index and adding to this amount all Medicare pass-through payments utilizing data obtained from the most recent cost report. The result will be divided by Medicare cases for the corresponding period.

Step 2: The average payment rate per Medicaid case with case mix removed will be calculated by dividing total Medicaid payments subject to case mix by the Medicaid case mix index calculated utilizing Medicare relative weights and adding to this amount all other Medicaid payments. The result will be divided by the number Medicaid cases for the corresponding period.

Step 3: The difference between the average payment rate per Medicare case with case mix removed and the average payment rate per Medicaid case with case mix removed will be multiplied by the Medicaid case mix and the number of Medicaid cases. The result is the gap between the Upper Payment Limit (UPL) and Medicaid payments for the applicable period.

Step 4: The difference between the average charge per Medicaid case and the average Medicaid payment rate per Medicaid case will be multiplied by the number of Medicaid cases. The result is the charge gap for the applicable period.

Step 5: The total supplemental payment will be equal to the lesser of the UPL Gap calculated in Step 3 and the Charge Gap calculated in Step 4.

- C. Any payments made under this section are subject to the payment limitation as specified in 42 CFR 447.271 whereby the total overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.
- D. In the event that any payment made under this section is subsequently determined to be ineligible for federal financial participation (FFP) by the Centers for Medicare and Medicaid Services, the Department shall adjust the payments made to any hospitals to qualify for FFP.

(16) Upper Payment Limit

The state agency will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for the services under the Medicare principles of reimbursement. Medicare upper payment limits as required by 42 CFR 447.272 will be determined in advance of the fiscal year from cost report and other applicable data from the most recent rate setting as compared to reimbursement for the same period. Cost data and reimbursement shall be trended forward to reflect current year upper payment limits.

(17) Supplemental Payments for Psychiatric Access Hospitals

For services provided on and after April 2, 2001 the Department shall provide supplemental payments to certain hospitals to assure access to psychiatric services for patients in rural areas of the Commonwealth. To qualify for psychiatric access payments a hospital must meet the following criteria:

1. The hospital is not located in a Metropolitan Statistical Area (MSA):
2. The hospital provides at least 65,000 days of inpatient care as reflected in the Department's Hospital Rate data for Fiscal Year 1998-99;
3. The hospital provides at least 20% of inpatient care to Medicaid eligible recipients as reflected in the Department's Hospital Rate data for State Fiscal Year 1998-99; and
4. The hospital provides at least 5,000 days of inpatient psychiatric care to Medicaid recipients in a fiscal year.

Each qualifying hospital will receive a psychiatric access payment amount based on its proportion of the hospital's Medicaid psychiatric days to the total Medicaid psychiatric days for all qualifying hospitals applied to the total funds available for these payments. Payments will be made on a quarterly basis in according with the following:

Medicaid patient days

Total Medicaid patient days X Available Fund = Payment

Total Medicaid payments to a hospital from all sources shall not exceed Medicaid charges plus disproportionate share payments. A hospital's disproportionate share payment shall not exceed the sum of the payment shortfall for Medicaid services and the costs of the uninsured. The available fund shall be an amount not to exceed \$6 million annually.

(18) Supplemental payments for non-state government-owned hospitals.

- A. The Department provides quarterly supplemental payments to certain non-state government-owned hospitals for services provided to Medicaid patients. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to the qualifying hospitals for services to Medicaid patients and the maximum allowable under applicable federal regulations in accordance with 42 CFR 447.272.

To qualify for a supplemental payment, a hospital must be a non-state government-owned hospital and must have entered into an Intergovernmental Transfer Agreement with the Commonwealth. The payment amount for a qualifying hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's Medicaid days provided during the most recent fiscal year by the total Medicaid days provided by all qualifying hospitals for the same fiscal year.

A payment made to a hospital under this provision when combined with other payments made under the non-disproportionate provisions of the state plan shall not exceed the limit specified in 42 CFR 447.272.

These supplemental payments shall end on June 30, 2005.

- B. Commencing July 1, 2005, the Department will provide inpatient supplemental payments to non-state, government-owned hospitals for services provided to Medicaid patients. These payments will be determined by calculating the difference between the aggregate amount paid for inpatient services provided to Medicaid patients and the estimated aggregate payment amount for such services if payments were based on Medicare payment principles, or the upper payment limit gap (UPL Gap).

The estimated aggregate payment amount for Medicaid services if payment were based on Medicare payment principles will be determined by calculating the sum of the average payments determined by applying Medicare payment principles for each hospital multiplied by the number of estimated cases for each hospital for the applicable payment period. The average payment

rate under Medicare for acute care inpatient hospital stays for each hospital will be determined by calculating the hospital-specific payment rate in accordance with the Medicare Inpatient Prospective Payment system. In determining this amount the case mix index for the Medicaid population will be calculated utilizing Medicare relative weights. The average payment rate for services provided by hospital units excluded from the Medicare Inpatient Prospective Payment system will be calculated in accordance with Medicare cost based principles of reimbursement.

The amount of the aggregate UPL Gap will be distributed to individual non-state, government-owned hospitals based on the individual hospital's fee-for-service inpatient days as a proportion of total fee-for-service inpatient days for non-state, government-owned hospitals. In the event such a payment would exceed an individual hospital's charge limit, the amount in excess of the individual hospital's charge limit will be allocated to other non-state, government-owned hospitals eligible to receive additional payments without exceeding their charge limit. Individual hospital payments may also be reduced in order to assure that an individual hospital's net payments do not exceed 2004 net payments. In the event a hospital's net payments are reduced to assure net payments do not exceed 2004 net payments, the amount in excess of the hospital's 2004 net payment will be allocated to other non-state, government-owned hospitals eligible for payment.

Inpatient supplemental payments described above will be made at least quarterly.

A payment made to a hospital under this provision when combined with other payments under the non-disproportionate provisions of the state plan shall not exceed the limit specified in 42 CFR 447.272.

(19) Supplemental Payments for Private Hospitals

Private hospitals (non-government owned or operated) qualify to receive supplemental payments from a pool in an amount to be determined annually by the Department. The Department will establish a pool in an amount equal to (a) one-half of the payments made to participating facilities under (18) of Attachment 4.19-A, page 14, and section F of Attachment 4.19-B, page 20.12(g) after (b) deducting the non-federal share of the payments, less the funds necessary to reimburse the participating facilities' Medicaid "shortfall", [defined as the difference between their aggregate payments for all inpatient hospital services (exclusive of disproportionate share payments) and their aggregate allowable costs of providing inpatient hospital services]. This amount shall be matched with federal financial participation to establish the total fund.

The supplemental payments shall be made quarterly and distributed proportionately among qualifying hospitals to the extent of their Medicaid costs as compared to the total Medicaid costs of all qualifying hospitals, not to exceed its "shortfall". The pool will be distributed pro rata, so that each qualifying hospital will receive a percentage of the pool equal to its pro rata share of the aggregate Medicaid costs of all qualifying hospitals.

The "shortfall" will be calculated on a per diem or per discharge basis, using the most recent cost reports used to establish hospital rates, and applied to claims data from the MMIS for the most recently completed fiscal year. Revenues or costs associated with days of care provided under managed care arrangements shall not be considered in determining the shortfall.